Volunteers of America MINNESOTA

Bar-None Residential Treatment Services
22426 St. Francis Blvd.
Anoka, MN 55303
www.voamn.org
Phone 763-753-2500 Fax 888-965-5125

Referral Information Checklist

Please include the following information when making a referral to Bar-None.

- ☐ Completed referral information form
- ☐ Relevant legal documentation (custody papers, court orders)
- ☐ Copies of insurance cards
- ☐ Clinical information including:
  - Most recent Psychological /Psychiatric Assessment/Diagnostic Assessment (within the last 6 months)
  - Treatment summaries (hospital, day treatment, outpatient)
  - Psychological/Neuropsychological testing reports
- ☐ Most recent Individualized Education Program (IEP) and IEP Evaluation
- ☐ Immunization records

Send to:

Bar-None Residential Services
ATTN: Shelly Manke

Fax: 888-965-5125
Email: smanke@voamn.org
Mail: 22426 St. Francis Blvd.
Anoka, MN 55303

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Bar-None Referral Information Form

Date:

CLIENT INFO					
Name *(last, first, middle)*:				Admission Unit:	
Nickname:		DOB:		Admit Date/Time:	
Age:	Sex:	Place of Birth:		IQ:	SSN:
Court ordered:	Custody:	Adjudicated:		Religious activities: ☐ Yes ☐ No	
Race:	Language:	Tribal affiliation:		Spiritual affiliation:	
Primary Medical Doctor/Clinic: (address & phone)		Last school attended: (address, phone & contact)			
SDRS: ☐ Yes ☐ No ☐ N/A		District #:		Grade:	

REFERRING AGENT			
Name:	County:	Phone:	Fax:

REASON FOR REFERRAL		
Previous or current charges?	☐ Yes ☐ No	Explain:
Is the youth a danger to him/herself?	☐ Yes ☐ No	Explain:
If yes, have there been any recent or significant suicide attempts?	☐ Yes ☐ No	Explain:
Is the youth a danger to others?	☐ Yes ☐ No	Explain:
Chemical abuser and/or chemically dependent?	☐ Yes ☐ No	Explain:
Have there been any inappropriate sexual behaviors?	☐ Yes ☐ No	Explain:
If yes, is youth a sex offender?	☐ Yes ☐ No	Explain:
Is youth currently hallucinating or having delusions or any concerns of this within the last three months?	☐ Yes ☐ No	Explain:
Previous DA?	☐ Yes ☐ No	Date:
Where is youth currently? (name & address) *(Admissions from Rice Institute, Willmar Mon-Thurs due to 1 day of medication given upon discharge.)*		
Reason for referral/presenting problems:		
If evaluation, what specifically are you looking for?		
Youth strengths?		
Current medications, including injectable meds, and prescribing physician:		
Are they taking meds to manage seizures? ☐ Yes ☐ No		Explain:
Is the youth an insulin-dependent Diabetic? ☐ Yes ☐ No		Explain:
Hx of major illnesses, surgeries, broken bones? ☐ Yes ☐ No		Explain:
Any pending medical/dental appointments? ☐ Yes ☐ No		Explain:
Does the youth have any food/drug allergies? ☐ Yes ☐ No		Explain:
Does the youth need an Epi-Pen for any reason? ☐ Yes ☐ No		Explain:
Has the youth ever had a positive Mantoux? ☐ Yes ☐ No		Explain:

If you answered YES to any of the above medical questions, you will be contacted by our nurse prior to acceptance.

COUNTY INFO	
Social Worker: Address: Phone: Fax: Email:	Probation Officer: Address: Phone: Fax: Email:
PARENT INFO	
Mother: Address: Phone: Email: DOB:	Father: Address: Phone: Email: DOB:
BILLING INFO	
Current MA #	MA Verified ☐ *Yes* ☐ *No*
Insurance Info	Policy Holder's Name
ID/Policy #	Policy Holder's DOB
Group #	Relationship to Youth
Per Diem Billing *(county or insurance)*	Medical Billing *(insurance or MA)*
BAR-NONE MENTAL HEALTH SCREENING ASSESSMENT	
Person screening	
Diagnosis at Intake DSM V (ICD-10)	
How is the program able to meet the youth's needs? *(Cultural, emotional, educational, mental health, physical, etc.):*	
Do further assessments need to be completed such as the POSIT and/or Rule 25? ☒ *Yes* ☐ *No* ☒ Complete all intake assessments ☐ Other assessments, explain:	
Accepted for Program ☐ *Yes* ☐ *No* If no, explain:	
Program recommended:	
COLLATERAL DOCUMENTATION	